

the concern appears to have branches or agents scattered throughout the country. So far as we know, it is without scientific standing. Its 'treatment' has been variously known as the 'Health Fume System', the 'Mineral Fume Bath', and also as 'Hal-A-Fum', the latter being, apparently, a modification of the former, intended primarily for self-treatment.

"It has been claimed that the Class Health Fume 'permits the system to absorb through the pores and put into the blood those mineral elements which the body at the time may lack'. The thing is, apparently, recommended for whatever ails you.

"We might add that in April, 1934, the California Board of Medical Examiners started an investigation, the outcome of which we do not yet know, of the John F. Class scheme, after a Long Beach woman complained that her eardrums were permanently injured as a result of one of the Class 'baths'. She stated that the reason she took the treatment was because the Class people 'invited a group of our club members to come and hear their lecture and gave us \$5 for our club fund and a free ticket for a bath, as a means of advertising'."

#### What is the Best Treatment for Mycosis Fungoides?

A young medical man in Paris, France, has been the subject of a very acute attack of Mycosis fungoides. Treatment with x-ray and malaria has not produced any great benefit. He writes the *Journal* to know if any of our members can give him useful suggestions or could refer him to any pertinent articles on the subject in the literature. Any replies to his request will be transmitted to him by the *Journal*.—EDITOR.

## Abstracts from Current Literature

### Surgery

**The Essential Features in Fractures of the Shoulder.** Wilson, G. E., *Surg., Gyn. & Obst.*, 1937, 64: 347.

The era when fractures were treated by general practitioners has passed; they are being treated by surgeons interested in traumatic surgery. In order to get a more comprehensive understanding Wilson undertook some original investigations, the better to define the positions of the great and lesser tuberosities in six positions of the humerus. By placing fine wires around their borders he was able to exactly delineate their x-ray shadows. The first position was antero-posterior, arm by side with forearm pointing upwards, or forearm extended and

hand supinated; lesser tuberosity and neck well outlined. The second was the humerus internally rotated 30 degrees; lesser tuberosity well shown and great tuberosity moderately so. Third position, forearm across chest; both tuberosities well shown. Fourth position, full internal rotation (arm behind back); anatomical neck, head and great tuberosity clearly defined, with lesser tuberosity projecting medially as a cone-shaped mass. Fifth position, external rotation of 60 degrees; appearance much as in position 4. but reversed. Sixth position, internal rotation 60 degrees with flexion 30 degrees; head appears as a cyst-like mass occupying the full upper extremity; great tuberosity on lateral aspect and lesser tuberosity on medial aspect.

Further investigations were made of the movements of the proximal and distal fragments in transverse fractures of the surgical neck experimentally produced. The distal fragment could be moved freely in all directions except posteriorly to the proximal fragment (pectoralis major). The proximal fragment could be abducted, adducted and flexed with ease, but extension was difficult (infraspinatus and teres minor). Internal rotation occurred readily but external rotation required a very considerable twist (supraspinatus tendon of insertion and to a much less degree subscapularis, as division close to blending with capsule proved). With the proximal fragment abducted, flexed 30 degrees and internally rotated 60 degrees, cyst-like appearance is marked; great tuberosity projects about one-fourth inch above the head, and the lesser tuberosity is near inner margin of head. With the proximal fragment adducted 20 degrees, internally rotated and flexed, the head stands out behind and above the great tuberosity, the anterior margin of which extends vertically with cone-like projection of the lesser tuberosity to the inner side. With the proximal fragment abducted, extended 30 degrees and no rotation, the anatomical neck was clearly seen, the head pointed inwards, with a conical projection (great tuberosity) on the outer side.

The author reviewed 100 cases of fracture of the upper end of the humerus, most of which were transverse of the surgical neck. If the proximal fragment was abducted the shaft was usually to the outer side of the proximal fragment; if adducted, shaft was usually medial; if flexed, the shaft was usually anterior and with internal rotation was twice as often adducted. Flexion was present in 50 per cent and internal rotation in over one-third; the combination is a very common occurrence. Dr. Wilson treats these fractures by placing the shaft in alignment with the proximal fragment, with due regard to the advantages of some abduction in case of possible ankylosis, by plaster of Paris, and the use of fluoroscope and post-operative x-rays in two planes.

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